IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

ANGELA SANTIAGO,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. No. 03-009-SLR
	)	
JO ANNE B. BARNHART, Commissioner of Social Security,	)	
	)	
Defendant.	)	

Gary C. Lundarducci, Esquire, New Castle, Delaware. Attorney for Plaintiff.

Colm C. Connolly, United States Attorney, and Paulette K. Nash, Assistant United States Attorney, United States Attorney's Office, Wilmington, Delaware. Counsel for Defendant. Of Counsel: James A Winn, Regional Chief Counsel and Nora Koch, Assistant Regional Counsel, Social Security Administration, Philadelphia, Pennsylvania.

MEMORANDUM OPINION

Dated: December 9, 2003
Wilmington, Delaware

ROBINSON, Chief Judge

I. INTRODUCTION

Plaintiff Angela Santiago filed this action against Jo Anne Barnhart, Commissioner of Social Security ("Commissioner"), on December 11, 2002. (D.I. 3) Plaintiff seeks judicial review pursuant to 42 U.S.C. § 405(g) of a decision by the Commissioner denying her claim for supplemental security income and disability insurance benefits under Titles II and XVI of the Social Security Act, 42 U.S.C. §§ 401-33, 1381-83f. Currently before the court are the parties' cross-motions for summary judgment. (D.I. 14, 16). For the reasons stated below, the court will grant defendant's motion, and deny plaintiff's.

II. BACKGROUND

A. Procedural History

On December 7, 2000 plaintiff filed a claim for supplemental security income and disability insurance benefits due to asthma, high blood pressure, a heart condition, and an injury to her neck, shoulder and hip. (D.I. 10 at 61) Plaintiff's claims were denied initially and upon review. Plaintiff requested and subsequently received a hearing before an administrative law judge ("ALJ"), that hearing being held on January 24, 2002. On February 22, 2002, the ALJ issued a decision denying plaintiff's claim. In considering the entire record, the ALJ found the following:

1. The claimant meets the nondisability requirements for a period of disability and Disability Insurance Benefits set fourth in Section 216(I) of the Social Security Act and is insured for benefits through the date of this decision.

2. The claimant has not engaged in substantial gainful activity since the alleged onset of disability.

3. The claimant's asthma, conductive hearing loss, and cervical and lumbar degenerative disc disease are considered "severe" impairments based on the requirements in the Regulations (20 CFR §§ 404.1520(b) and 416.920(b)).

4. These medically determinable impairments do not meet or medically equal one of the listed impairments in Appendix 1, Subpart P, Regulation No. 4.

5. The undersigned does not find the claimant's testimony and allegations fully credible regarding the severity of her impairments and symptoms and their effect on her functional abilities.

6. The undersigned has carefully considered all of the medical opinions in the record regarding the severity of the claimant's impairments (20 CFR §§ 404.1527 and 416.927).

7. The claimant has the following residual functional capacity: she is able to lift 10 pounds; stand and walk for up to two hours in an eight-hour workday; sit for up to six hours in an eight-hour workday; and perform jobs not involving climbing, repetitive reaching above 90 degrees, temperature extremes, or respiratory irritants.

8. The claimant's past relevant work as a receptionist did not require the performance of work-related activities precluded by her residual functional capacity. (20 CFR §§ 404.1565 and 416.965)

9. The claimant's medically determinable asthma, conductive hearing loss, and cervical and lumbar

> degenerative disc disease not prevent the claimant from performing her past relevant work.
>
> 10. The claimant was not under a "disability" as defined in the Social Security Act, at any time through the date of the decision (20 CFR §§ 404.1520(e) and 416.920(e)).

(D.I. 10 at 18-19) On October 22, 2002, the Appeals Council declined to review the ALJ's decision and his decision became the final decision of the Commissioner. (Id. at 6-7) Plaintiff now seeks review before this court pursuant to 42 U.S.C. § 405(g).

B. Facts Evinced at the Administrative Hearing

Plaintiff was born on January 10, 1954, and was 46 years old on February 26, 2000, the date of onset of the alleged disability. She completed the seventh grade in Puerto Rico and subsequently obtained a certificate in business and clerical work in 1997. (Id. at 342-43). In the past, plaintiff has worked as a sales clerk, stock clerk, line cook, and receptionist. (Id. at 343-44) As a receptionist, plaintiff greeted people, answered the phone, and took messages. (Id. at 344)

Plaintiff injured her neck, shoulder, and right arm while working as a stock clerk at Caldor. (Id. at 345) That business is no longer operating. (Id.) Since leaving Caldor, plaintiff has attempted to find work on only one occasion. She was allegedly told that because she did not walk straight, she would not be hired. (Id.) Plaintiff testified because of the pain, stress, and emotional distress, she is unable to look for

employment. (Id. at 349) Plaintiff testified that she feels pain in her neck, shoulders, right arm and in the lower back near her hip. (Id. at 345) She testified that she is currently receiving injections of cortisone for her back pain. She is also receiving physical therapy at a therapy center in Greenville for the pain in her right arm. She attended physical therapy ten times in the three weeks prior to her hearing before the ALJ. (Id. at 346) Plaintiff testified that in 1999, 2000, and 2001 she similarly received physical therapy provided through Medicaid. Plaintiff also alleges that she suffers from migraines, high blood pressure, a heart condition and depression, for which she has been prescribed Zoloft. (Id. at 347) Plaintiff testified that she had three lumps in her left breast and that the physician did not inform her as to whether they were benign or malignant. (Id. at 348)

Plaintiff testified that she can sit generally for no more than twenty-five minutes before she feels pains. (Id. at 354) She stated that after twenty-five minutes, she feels muscle spasms and tingling in her arm and numbness in her leg. (Id.) Plaintiff also indicated that she ambulates with the use of a cane. (Id.) She stated that she can stand for approximately thirty minutes without pain, after which she experiences numbness in her arm, back and neck. (Id.) During the day, plaintiff testified that she would lie down approximately two or three

times each hour, so that during the hours of 8:00 am to 5:00 pm, she'll be lying or reclining four or six hours of that nine hour period. (Id. at 354-55) Plaintiff stated that she takes hydrocodon and Lortab, which give her some pain relief. (Id. at 355)

Plaintiff testified that the pain has resulted in a decrease in certain daily activities including cooking, housecleaning, writing, shopping and attending church. (Id. at 356-68) Plaintiff stated that she has anxiety about being in crowds, for fear of furthering aggravating her injury. (Id. at 357) She also testified that she had difficulty watching television for longer than an hour, as she has difficulty staying awake. (Id. at 358) She indicated that part of this resulted from her medication which causes her to be sleepy. (Id. at 359) Plaintiff indicated that she experiences vision-related side effects from her Zoloft prescription. (Id.) She testified that she takes between fifteen and twenty pills each day,[1] the combination of which results in dizziness. (Id. at 360)

C. Vocational Expert

Dr. Andrew Beale testified as an impartial vocational expert as to plaintiff's work history and applicable physical exertion category and skill requirements. (Id. at 361-62)

Dr. Beale characterized plaintiff's previous jobs as

[1]Including medication for high cholesterol.

follows: (1) work as a retail sales clerk is semi-skilled and requires light physical exertion; (2) work as a line cook in a fast food establishment is semi-skilled and requires medium physical exertion; (3) work as a receptionist is semi-skilled and is sedentary; and (4) work as a stock clerk who engages in inventory pricing is semi-skilled and sedentary. (Id. at 362)

Dr. Beale testified that, assuming a residual functional capacity for sedentary work, plaintiff has transferable job skills for low level, semi-skilled, sedentary general clerical jobs, including telephone solicitors, order clerks, information clerks and appointment clerks. (Id) Dr. Beale testified that for the position of telephone solicitor and order clerks, there are approximately 380 jobs in the State of Delaware and 157,900 jobs in the national economy. (Id.) For the position of information clerk, there are 500 jobs available in Delaware, and 156,000 jobs in the national economy. For the position of appointment clerk, Dr. Beale testified that there are 1900 positions in Delaware, and 600,000 jobs in the national economy. (Id. at 363)

Dr. Beale testified that the use of a cane to ambulate would not normally significantly interfere with the completion of the job requirements for the sedentary positions he discussed. (Id. at 364)

Dr. Beale testified that a younger person of the same work

experience and education as plaintiff, who can lift up to twenty pounds occasionally, ten pounds frequently, and can stand and/or walk up to six hours without the use of a cane to ambulate, would be able to perform unskilled light inspecting work, such as a food service worker or laundry sorter. (Id.) Dr. Beale testified that there are 480,000 such food service positions in the national economy, and 1,800 jobs in Delaware. Dr. Beale also testified that there are 68,000 laundry sorting positions in the national economy, 200 jobs in Delaware. (Id.) The use of a cane, however, would preclude such a person from a job as a food service worker or laundry sorting. (Id.) Dr. Beale opined that a bilateral limitation of reaching only to the shoulder level would not preclude unskilled light inspecting work, such as a food service worker or laundry sorter.

Dr. Beale was asked by the ALJ to consider whether there is work available for a hypothetical person that is of a younger age, same education and work experience as plaintiff who could lift up to ten pounds occasionally; stand and walk for up to two hours; sit for up to six hours; perform various postural maneuvers that can be done occasionally with the exception of not climbing ladders, ropes, or scaffolds; may not reach above ninety degrees or shoulder height level repeatedly; may not be exposed to extreme temperature or respiratory irritants; requires a cane to ambulate; and may not perform work involving exposure to

hazardous heights or dangerous moving machines. Dr. Beale indicated that the positions of appointment clerk, order clerk and information clerk were examples of general clerical jobs which would meet those limitations. (Id. at 366) Dr. Beale also testified that assembler jobs and sedentary inspecting jobs would also fall within those limitations. (Id.) Dr. Beale indicated that there were 490 assembler jobs available in Delaware, 160,000 jobs in the national economy, and 125 sedentary inspecting jobs in Delaware, 150,000 jobs in the national economy. (Id.) He added that these unskilled sedentary jobs he described were representative, and not exclusive nor exhaustive of positions available in Delaware and the national economy. (Id.)

Dr. Beale testified that a right-handed person who experienced pain associated with the use of her right hand, would only be significantly limited if the pain was of such severity and duration that it precluded the frequent use of that hand. (Id. at 367) Dr. Beale also testified that someone who takes medication, a side-effect of which is sleepiness, would be preclude from the work he previously described if her production standard and quality were adversely affected by her condition. (Id.) He testified that a person who experienced pain so severe that it precludes her concentration and attention fifty percent of the time would be precluded from the sedentary jobs he

described. (Id.) Finally, Dr. Beale testified that, if the ALJ accepted plaintiff's testimony as credible, including her statement that she had to lie down for four hours during a work day, she would not be able to perform the work required in the sedentary jobs he previously described. (Id. at 368)

D. Medical History

Dr. Leo W. Raisis treated plaintiff from July 22, 1998 to June 14, 2000. Plaintiff had a magnetic resonance imaging ("MRI") performed at Westside Health, Inc. on December 6, 1999. Dr. Howard Rubenstein, the reviewing physician, indicated that she had a mild spondylitic spur formation throughout the lumbar spine. (Id. at 126)

On March 15, 2000, plaintiff reported that she had right cervical trapezial pain aggravated by a December 1999 fall from an examination bed during cardiac testing. (Id. at 149) Dr. Raisis indicated that plaintiff expressed tenderness with forward flexion of 90 degrees and abduction of 80 degrees. (Id.) A neurological examination indicated that plaintiff had normal motor, sensory and reflex function. Dr. Raisis recommended continued conservative treatment. (Id.)

On March 20, 2000, a subsequent lumbar MRI was interpreted by Dr. Karen Carmody to show no herniated discs or spinal stenosis, a focal annular tear at the L5-S1 level, and a mild diffuse disc bulging at L4-5 and L5-S1. (Id. at 118) In a June

15, 2000 follow-up, x-rays indicated that plaintiff's right scapula were normal. (Id. at 148) Dr. Raisis recommended conservative treatment of plaintiff's condition. (Id.)

On January 29, 2001, plaintiff was referred to Dr. Lewis S. Sharps for consultation on her chronic lower back pain and left hip pain. (Id. at 217) A physical examination indicated pain with motion of the left hip joint. Plaintiff's neurological examination of the lower extremities was reported as normal. X-rays of plaintiff's left hip were normal, but x-rays of the lumbar spine demonstrated an abnormality of the L5 vertebral body.

On February 13, 2001, Dr. Sharps ordered MRIs of the left hip and an MRI of the lumbar spine for an assessment of lower back, hip and leg pain. (Id. at 224-25) The diagnostic impression from the left hip MRI was that there was no evidence of degenerative changes, joint effusion, or bursitis. (Id. at 224) The impression from the lumbar spine MRI was that plaintiff's lumbar vertebrate were normal except for a small central disc herniation at L4-5 with inferior disc extrusion. (Id. at 225) The lumbar spine MRI also determined that there was no evidence of spinal stenosis. (Id.)

Dr. Christine Donohue-Henry ordered an MRI of the cervical spine on December 18, 2001. (Id. at 278-80) Dr. Stanton Kaofsky interpreted the exam and reported that there was moderate

degenerative disc disease at C5-6 associated with endplate degenerative spurring; right paracentral herniation which was the likely cause of ventral impression upon the anterior CSF that approaches the central cord; and a mild amount of central canal stenosis at C5-6.[2] (Id. at 278-80)

Dr. Jose S. Picazo treated plaintiff during a period between June 25, 2001 and December 26, 2001 for back and lower extremities related complaints.[3] (Id. at 276-77) On June 25, 2001, Dr. Picazo noted that a February 14, 2001 lumbar spine MRI revealed a small central disc herniation at L4-5 with inferior disc extrusion. (Id. at 276) He also noted that a neurological examination of the lower extremities reported normal findings, except there was tenderness in the lower lumbar spine area. Dr. Picazo ordered several tests and a series of epidural injections. (Id.) At a December 26, 2001 follow-up, Dr. Picazo noted that there was not a dramatic response to the epidural injections, and that plaintiff continued to have pain. Dr. Picazo's diagnostic impression was that the pain was likely attributed to the extruded disk.

Plaintiff began receiving pain management treatments from Mid-Atlantic Spine Institute in October 2001 directed toward her

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[2]Dr. Kaofsky noted that he did not have previous imaging reports from which to compare these findings. (Id.)

[3]Dr. Picazo treated plaintiff on April 19, 2001 for an adnexal mass. (Id. at 273-74)

complaints of neck, shoulder, and back pain. (Id. at 298-324) On January 7, 2002, she rated her pain as a six on a Numerical Analog Scale of zero to ten.[4] (Id. at 298) This was the same rating she gave the pain on her previous visits on October 31, December 13, and December 27 in 2001. (Id. at 301, 304, 307) On December 17, 2001, plaintiff indicated that her pain had elevated to a 7-8 on the clinic's pain scale, but that her relief since her last visit had been approximately forty percent (Id. at 319-20) Plaintiff also reported that she had obtained thirty percent improvement in pain relief since her previous visit at both her December 27, 2001 and January 7, 2002 visit.[5] (Id. at 299, 302)

From November 30, 1999 to December 19, 2000, plaintiff received treatment from Dr. Ronald A. Lewis at Cardiology Consultants. On November 30, 1999, Dr. Lewis concluded that, while plaintiff had elevated blood pressure and a history of hypertension, the chest discomfort she experienced was non-cardiac in nature. (Id. at 189) Dr. Lewis recommended dietary

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[4]The pain scale reports the following benchmarks for severity: "0 (no pain); 1-2 (tolerate without medications); 3-4 (tell someone about my pain take aspirin or Motrin); 5-6 (mild narcotic, ex. Tylenol #3); 7-8 (go to ER, take strong narcotics)l 9-10 (admission to hospital for pain control)." (Id. at 298)

[5]Inexplicably, the December 13, 2001 patient information sheet indicates in several places that it was plaintiff's first visit to the Mid-Atlantic facility. (Id. at 304-05) This is despite the October 31, 2001 patient information sheet and the inital examination report, dated October 22, 2001, by Dr. Frank J.E. Falco. (Id. at 310-311)

changes and weight loss. (Id.) A December 2, 1999 echocardiogram reported normal functioning. (Id. at 185) Plaintiff had an ejection fraction of sixty-five percent. On December 19, 2000, Dr. Lewis' diagnosis of plaintiff's condition included hypertension, morbid obesity, a history of supraventricular tachycardia, hyperlipidemia, cervical degenerative joint disease, and a history of asthma. (Id. at 177) Dr. Lewis concluded that plaintiff was stable from a cardiac perspective, that her medications were effective, and that she displayed no cardiac dysrhythmia. (Id)

Plaintiff received treatment from Dr. Joseph I. Ramzy for conductive hearing loss and a persistent left middle ear effusion between November 3, 2000 and May 9, 2001. Dr. Ramzy prescribed Medrol DosePak, Duravent, and Amoxicillin with some improvement demonstrated. (Id. at 203) On March 27, 2001, Dr. Ramzy performed a left myringotomy and placed a pressure equalizing ventrilation tube to relieve the serous effusion. (Id. at 199) On April 4, 2001, Dr. Ramzy reported that the procedure had relieved the effusion. (Id. at 198)

Plaintiff sought treatment from Dr. Pecos T. Olurin on November 21, 2000, complaining of blurry vision. Upon examination, Dr. Olurin reported that plaintiff had 20/20 vision. (Id. at 211)

Dr. Irwin Lifrak conducted a consultative medical evaluation

on behalf of Delaware Disability Determination Services ("DDS") on February 11, 2001. (Id. at 218) Dr. Lifrak noted that plaintiff had complaints of pain from her neck down to her feet, shortness of breath, and headaches. (Id.) Dr. Lifrak observed that plaintiff was 61 inches in height and weighed 237 pounds. (Id. at 220) Dr. Lifrak noted that plaintiff had a grip strength of 40 pounds with her left hand, and 25 pounds with her right hand. (Id.) Dr. Lifrak observed no evidence of muscle atrophy or deformities involving the upper or lower extremities. (Id.)

Dr. Lifrak's diagnostic impressions were that plaintiff's back and shoulder pain were the result of a degenerative joint disease; plaintiff's shortness of breath was consistent with asthma or persistent bronchitis, but that in the past year such symptoms were not so severe as to require hospitalization; plaintiff's hypertension was not adequately controlled and the likely cause of her headache episodes. (Id. at 221) Dr. Lifrak concluded that plaintiff should ambulate with a single cane; plaintiff should not, during an eight-hour day, sit for more than one hour or stand for a period of more than 30-45 minutes; plaintiff is able to life weights of up to five pounds on a regular basis, although with her right hand she should not lift such weights above shoulder height. (Id.)

An RFC assessment performed by a DDS physician on February 23, 2001, considered the February 1, 2001 report of Dr. Lifrak,

and determined that plaintiff could lift and/or carry up to ten pounds occasionally, and less than ten pounds frequently; stand and/or walk at least two hours in an eight hour work day and; and sit up to six hours in an eight hour work day. (Id. 226-35) The DDS physician found that, while the symptoms were attributable to a medically determinable impairment, patient's reporting of the severity and duration of the symptoms were disproportionate with objective medical evidence and only partially credible. (Id. at 233) The physician concluded that plaintiff had a sedentary RFC. (Id. at 233, 235)

A second RFC was performed by a DDS physician on July 19, 2001. (Id. at 236-45) That physician concurred with the physical exertional limitations conclusions made by the February 23, 2001 RFC. (Id. at 237)

A third RFC evaluation was provided by Dr. Sharps, plaintiff's treating physician, on January 23, 2002. (Id. at 272) That evaluation indicated that plaintiff could carry up to ten pounds frequently; stand or walk for one to two hours at a time, for a total of two to four hours in an eight hour work day; sit for two to three hours at one time, for up to four to six hours in an eight hour work day; and that plaintiff would not need to lie down during an eight hour work day. (Id.) Dr. Sharps indicated that plaintiff suffered from moderate pain, and indicated that plaintiff experienced severe pain fifty percent of

the time during a month period. (Id.) Dr. Sharps' evaluation was that plaintiff's pain would have a moderate affect on her ability to concentrate at work and on her ability to complete a day's workload. Dr. Sharps concluded that plaintiff could perform a sedentary job on a full-time basis. (Id.)

D. ALJ Decision

Having determined that plaintiff was not presently engaged in substantial gainful work, the ALJ first considered whether her asserted ailments constituted severe impairments within the meaning of the Social Security Act and regulations. The ALJ concluded that plaintiff's hypertension is not a severe impairment within the meaning of the Social Security Regulations. (Id. at 16) The ALJ based his decision on the fact that medical history indicated that her condition is controllable with medication. She has a history of cardiac arrhythmia but, during the relevant time period, there were no significant problems. (Id.)

The ALJ similarly concluded that plaintiff does not have a severe psychiatric limitation. (Id.) The ALJ based this finding on the fact that plaintiff has responded to treatment with medication, that there has not been any functional limitations resulting from her depression, and that it has not lasted longer than twelve months.

The ALJ found that "medical evidence indicated that

[plaintiff's] asthma, conductive hearing loss, and cervical and lumbar degenerative disc disease" were severe within the meaning of the Regulations, but not severe enough to "meet or medically equal one of the impairments" listed on the schedule in Appendix 1, Subpart P, Regulations No. 4.[6] (Id.) However, the ALJ also concluded that plaintiff's testimony at the hearing was not "full credible regarding the severity of her impairments and symptoms and their effect on her functional abilities." (Id. at 17) Relying upon the treatment reports, the ALJ concluded that plaintiff's pain was only mild to moderate, and that her spinal impairments were not so severe as to require surgical correction. The ALJ also noted that Dr. Picazo, a treating physician, concluded that plaintiff's conditions did not preclude work of a sedentary nature. (Id.)

The ALJ considered the RFC evaluations submitted by DDS physicians which indicated that plaintiff had the requisite mental and physical capabilities to perform sedentary work. (Id.) In light of the whole record, the ALJ concluded that plaintiff had the "residual functional capacity to lift 10 pounds of weight, stand or walk for up to two hours in an eight-hour workday, and sit for prolonged periods." (Id.) The ALJ also concluded that plaintiff "may require jobs not involving climbing

[6]The ALJ noted that the hearing loss may not have been a permanent condition but resolved that issue in plaintiff's favor, as it did not affect the ultimate outcome. (Id. at 16)

or repetitive reaching above 90 degrees . . . . exposure to temperature extremes or respiratory irritants." (Id.)

At step four in the evaluation process, the ALJ determined that plaintiff's past relevant work as a sales clerk, stock clerk, and line cook are classified as light to medium exertional level, and that plaintiff was unable to perform these jobs. (Id.) The ALJ concluded, however, that the occupation of receptionist is classified at a sedentary exertional level as it is performed in the national economy and that plaintiff's limitations would not prevent her from performing the job of receptionist. (Id.) Further, the ALJ found that the job of receptionist existed in significant numbers in the national economy for an individual of plaintiff's vocational profile and residual functional capacity. (Id.) The ALJ considered Dr. Beale's testimony that if plaintiff's complaints regarding pain were given full credibility, that she would not have the ability to perform the job of receptionist. However, the ALJ concluded that plaintiff's testimony was not fully credible. (Id.) Consequently, the ALJ reached a final conclusion that plaintiff was not disabled within the meaning of the Social Security Act at any time through the date of his decision.

III. STANDARD OF REVIEW

"The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, [are]

conclusive," and the court will set aside the Commissioner's denial of plaintiff's claim only if it is "unsupported by substantial evidence." 42 U.S.C. § 405(g) (2002); 5 U.S.C. § 706(2)(E) (1999); see Menswear Med. Ctr. v. Heckler, 806 F.2d 1185, 1190 (3rd Cir. 1986). As the Supreme Court has held,

> "[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Accordingly, it "must do more than create a suspicion of the existence of the fact to be established . . . . It must be enough to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury."

Universal Camera Corp. v. NLRB, 340 U.S. 474, 477 (1951) (quoting NLRB v. Columbian Enameling & Stamping Co., 306 U.S. 292, 300 (1939)).

The Supreme Court also has embraced this standard as the appropriate standard for determining the availability of summary judgment pursuant to Fed. R. Civ. P. 56:

> The inquiry performed is the threshold inquiry of determining whether there is the need for a trial — whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party.
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> Petitioners suggest, and we agree, that this standard mirrors the standard for a directed verdict under Federal Rule of Civil Procedure 50(a), which is that the trial judge must direct a verdict if, under the governing law, there can be but one reasonable conclusion as to the verdict. If reasonable minds could differ as to the import of the evidence, however, a verdict should not be directed.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 250-51 (1986) (internal citations omitted). Thus, in the context of judicial review under § 405(g),

> [a] single piece of evidence will not satisfy the substantiality test if the [Commissioner] ignores, or fails to resolve, a conflict created by countervailing evidence. Nor is evidence substantial if it is overwhelmed by other evidence — particularly certain types of evidence (e.g., that offered by treating physicians) — or if it really constitutes not evidence but mere conclusion.

Brewster v. Heckler, 786 F.2d 581, 584 (3rd Cir. 1986) (quoting Kent v. Schweiker, 710 F.2d 110, 114 (3rd Cir. 1983)). Where, for example, the countervailing evidence consists primarily of the claimant's subjective complaints of disabling pain, the Commissioner "must consider the subjective pain and specify his reasons for rejecting these claims and support his conclusion with medical evidence in the record." Mattel v. Bowen, 926 F.2d 240, 245 (3rd Cir. 1990).

IV. DISCUSSION

A. Disability Determination Process

Title II of the Social Security Act, 42 U.S.C. § 423(a)(1)(D), as amended, "provides for the payment of insurance benefits to persons who have contributed to the program and who suffer from a physical or mental disability." Bowen v. Yuckert, 482 U.S. 137, 140 (1987). A disability is defined as the "inability to engage in any substantial gainful activity by

reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months[.]" 42 U.S.C. § 423(d)(1)(A) (2002).

In Plummer v. Apfel, 186 F.3d 422 (3rd Cir. 1999), the Third Circuit outlined the applicable statutory and regulatory process for determining whether a disability exists:

> In order to establish a disability under the Social Security Act, a claimant must demonstrate there is some "medically determinable basis for an impairment that prevents him from engaging in any 'substantial gainful activity' for a statutory twelve-month period." A claimant is considered unable to engage in any substantial activity "only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy."
>
> The Social Security Administration has promulgated regulations incorporating a sequential evaluation process for determining whether a claimant is under a disability. In step one, the Commissioner must determine whether the claimant is currently engaging in substantial gainful activity. If a claimant is found to be engaged in substantial activity, the disability claim will be denied. In step two, the Commissioner must determine whether the claimant is suffering from a severe impairment. If the claimant fails to show that her impairments are "severe", she is ineligible for disability benefits.
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> In step three, the Commissioner compares the medical evidence of the claimant's

> impairment to a list of impairments presumed severe enough to preclude any gainful work. If a claimant does not suffer from a listed impairment or its equivalent, the analysis proceeds to steps four and five. Step four requires the ALJ to consider whether the claimant retains the residual functional capacity to perform her past relevant work. The claimant bears the burden of demonstrating an inability to return to her past relevant work.
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> If the claimant is unable to resume her former occupation, the evaluation moves to the final step. At this stage, the burden of production shifts to the Commissioner, who must demonstrate the claimant is capable of performing other available work in order to deny a claim of disability. The ALJ must show there are other jobs existing in significant numbers in the national economy which the claimant can perform, consistent with her medical impairments, age, education, past work experience, and residual functional capacity. The ALJ must analyze the cumulative effect of all the claimant's impairments in determining whether she is capable of performing work and is not disabled. The ALJ will often seek the assistance of a vocational expert at this fifth step.

Id. at 427-28 (internal citations omitted). If the Commissioner finds that a claimant is disabled or not disabled at any point in the sequence, review does not proceed to the next step. See 20 C.F.R. § 404.1520(a) (2002).

The determination of whether a claimant can perform other work may be based on the administrative rulemaking tables provided in the Social Security Administration Regulations ("the grids"). Cf. Jesurum v. Sec'y of Health & Human Servs., 48 F.3d

114, 117 (3rd Cir. 1995) (noting use of the grids for determination of eligibility for supplemental social security income) (citing Heckler v. Campbell, 461 U.S. 458, 468-70 (1983)). In the context of this five-step test, the Commissioner has the burden of demonstrating that the plaintiff is able to perform other available work. See Bowen, 482 U.S. at 146 n.5. In making this determination, the ALJ must determine the individual's residual functional capacity, age, education, and work experience. See 20 C.F.R. pt. 404, subpt. P, app. 2, § 200.00(c) (2002). The ALJ then applies the grids to determine if an individual is disabled or not disabled. See 20 C.F.R. pt. 404, subpt. P, app. 2, § 200.00(d) (2002).

If the claimant suffers from significant non-exertional limitations, such as pain or psychological difficulties, the ALJ must determine, based on the evidence in the record, whether these non-exertional limitations limit the claimant's ability to work beyond the work capacity obtained from reviewing the Social Security regulation "grids." See 20 C.F.R. § 404.1569a(c)-(d). If the claimant's non-exertional limitations are substantial, the ALJ uses the grids as a framework only and ordinarily seeks the assistance of a vocational specialist to determine whether the claimant can work. See Santise v. Schweiker, 676 F.2d 925, 935 (3rd Cir. 1982); 20 C.F.R. pt 404, subpt. P, app. 2, § 200(d)-(e).

C. Plaintiff's Subjective Complaints of Pain

In the case at bar, plaintiff challenges the Commissioner's decision on two counts: (1) the ALJ improperly rejected the medical opinion of Dr. Sharps; and (2) the ALJ improperly rejected the opinion of Dr. Lifrak. (D.I. 15 at 11, 13) In both cases, plaintiff's challenge relates to the credibility and weight given to her subjective complaints of pain. For the reasons stated below, the court finds that the findings of the Commissioner are supported by substantial evidence.

1. Consideration of Dr. Sharps' Opinion.

Plaintiff contends that the ALJ failed to consider Dr. Sharps' medical conclusion regarding the frequency with which plaintiff suffers from severe pain. Plaintiff further contends that the ALJ selectively and erroneously accepted Dr. Sharps' conclusion that plaintiff is able to perform sedentary work. (D.I. 15 at 12) Instead, plaintiff urges the court to accept Dr. Sharps' conclusion regarding severity and duration of pain, but ignore Dr. Sharps' conclusion regarding plaintiff's residual functioning capacity.

In question seven of the January 23, 2002 RFC assessment, Dr. Sharps described plaintiff's pain generally as moderate. (Id. at 272) Dr. Sharps responded affirmatively to question eight's inquiry as to whether plaintiff ever suffered severe pain. In a follow-up to that RFC question, Dr. Sharps was asked

how many days per month plaintiff experienced severe pain. Dr. Sharps response to that question was "50%." (Id.)

Dr. Sharps' response is susceptible to two interpretations. First, it could mean that during any given month, plaintiff experiences severe pain during fifty percent of the month. Second, Dr. Sharps' response could be interpreted to mean that during any given month, plaintiff experiences some severe pain on at least fifty percent of the days of that month, but not necessarily for the full day. The first interpretation, however, would be plainly inconsistent with both Dr. Sharps' overall assessment in question seven that plaintiff's pain was generally moderate, and his conclusion that plaintiff could perform sedentary work. Consequently, the most reasonable interpretation of Dr. Sharps' opinion, in light of the entire RFC assessment, is that plaintiff suffers from some severe pain during at least fifty percent of the days of the month, but that overall her pain is moderate. The court concludes, therefore, that the ALJ properly considered Dr. Sharps' opinion, and that the ALJ's conclusions are consistent with that medical opinion.[7]

D. Consideration of Dr. Lifrak's Opinion

[7]Plaintiff also contends that Dr. Sharp "went beyond his expertise when he opined" regarding plaintiff's residual functioning capacity. (D.I. 15 at 12) Plaintiff, however, cites neither a factual nor a legal basis for why her treating physician is not properly qualified to evaluate her symptoms and medical condition.

Plaintiff contends that the ALJ ignored the medical conclusions of Dr. Lifrak, namely, that plaintiff was not capable of performing sedentary work on a full time basis. (D.I. 15 at 13). The court concludes that plaintiff's argument is largely unsupported, and that the ALJ's conclusions are substantially supported by the record.

Plaintiff, in her statement of facts, states that Dr. Lifrak concluded "that [plaintiff's] severe degenerative joint disease would prohibit [plaintiff] from sitting or standing for a prolonged length of time and opined that she could not perform a sedentary job on a full time basis." (D.I. 15 at 13) The court finds this to be inconsistent with Dr. Lifrak's report. Having carefully reviewed Dr. Lifrak's report, the court is unable to find any place where Dr. Lifrak characterizes plaintiff's degenerative joint condition as "severe." A December 18, 2001 MRI indicated that the degenerative condition was moderate. (D.I. 10 at 278-80)

Dr. Lifrak did suggest exertional limitations which would be inconsistent with sedentary work, however, those limitations were based soley upon plaintiff's characterization of her pain, and not objective medical evidence. See infra pp 13-14. The regulations specifically provide that allegations of subjective symptoms cannot be the basis for disability, but that there must be medical signs and laboratory findings that show a medical

impairment that may be reasonably expected to produce pain or other symptoms alleged. 20 C.F.R. §§ 404.1529, 416.929 (2002).

The ALJ found plaintiff's characterization of her pain to be not fully credible. This conclusion is substantially supported by the record. Plaintiff's treating physicians agreed that her pain was best characterized as moderate, and that it would not affect her ability to perform sedentary work. (D.I. 10 at 273) Under agency rules, a treating physician's medical conclusions are generally given more weight. 20 C.F.R. § 404.1527(d)(2). The ALJ expressly relied on the treating physician's opinion, referencing both "treatment records" and the treating physician's conclusions regarding residual functioning capacity. (D.I. 10 at 17) The ALJ's conclusion is buttressed by the concurrence of a DDS physician that plaintiff's complaints are disproportionate with objective medical evidence. (D.I. 10 at 233)

Dr. Lifrak's objective medical findings, which the ALJ thoroughly discussed, do not suggest a medical basis for plaintiff's pain that is consistent with the duration and severity that she reports. See Jones v. Sullivan, 954 F.2d 125, 129 (3d Cir. 1991). Although the ALJ did not expressly reconcile Dr. Lifrak's opinion with that of other agency physicians and treating physicians as to plaintiff's ability to perform sedentary work, the ALJ is not required to expressly resolve each inconsistency in the record. Moreover, since the substantial

evidence supports the conclusion that plaintiff retained a residual functioning capacity, and Dr. Lifrak's conclusions could only be based upon his acceptance of plaintiff's subjective complaints of pain, the ALJ's decision was proper.

V. CONCLUSION

For the reasons stated above, the court shall grant defendant's motion for summary judgment and deny plaintiff's motion for summary judgment. An appropriate order shall issue.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

ANGELA SANTIAGO,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civ. No. 03-009-SLR
	)	
JO ANNE B. BARNHART, Commissioner of Social Security,	)	
	)	
Defendant.	)	

O R D E R

At Wilmington, this 9th day of December, 2003, consistent with the memorandum opinion issued this same day;

IT IS ORDERED that:

1. Plaintiff's motion for summary judgment (D.I. 14) is denied.

2. Defendant's motion for summary judgment (D.I. 16) is granted.

3. The clerk is directed to enter judgment in favor of defendant Jo Anne B. Barnhart and against plaintiff Angela Santiago.

Sue L. Robinson
United States District Judge